

STATE OF MAINE

STATE BOARD OF ALCOHOL AND DRUG COUNSELORS

APPLICATION FOR CERTIFIED ALCOHOL AND DRUG COUNSELOR



Department of Professional and Financial Regulation

Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8689
TTY/HEARING IMPAIRED 1-888-577-6690
FAX: (207) 624-8637

Office located at: 122 Northern Avenue, Gardiner, Maine
Email: voni.a.eames@maine.gov

<p style="text-align: center;">APPLICATION INSTRUCTIONS CERTIFIED ALCOHOL AND DRUG COUNSELOR</p>
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1. Submit a copy of birth certificate, driver's license, or passport.
2. Submit documentation of graduation from High School or equivalent GED certificate (If applying based on work experience).
3. Submit official transcripts (If applying based on Higher Education)(see 32 MRSA § 6214-C).
4. Submit a copy of driving record from the Maine Department of Motor Vehicles (or appropriate agency if you are from another state).
5. Submit the verification of clinically supervised hours (if applying based on work experience).
6. Submit verification from every state in which you hold or have ever held any type of license or credential to practice alcohol and drug counseling.
7. **Submit the fee of \$142.50 (\$25.00 non-refundable application fee, examination fee \$102.50 and criminal history record check \$15.00). If paying by check, make it payable to Treasurer, State of Maine. If paying by credit card, please submit the enclosed authorization form with your application.**

Examination Dates for 2006

License Category Examinations	Date of Exam	Deadline for application filing with the Board Office
All levels: CADC,LADC, and CCS	03/10/2006	01/25/2006
All levels	06/09/2006	04/27/2006
All levels	09/08/2006	07/27/2006
All levels	12/08/2006	10/26/2006

The Board of Alcohol and Drug Counselors requires that all supporting documents and fees be submitted with the filing of your application. Your application will be considered incomplete and will be returned if supporting documents and or fee are omitted. Documents that have been modified or altered in any way will not be accepted.

NOTE: This is an abbreviated checklist and does not replace the requirements outlined in the Alcohol and Drug Counseling Laws and Rules. Please review them carefully for more detailed and clarifying information.



STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
STATE BOARD OF ALCOHOL AND DRUG COUNSELORS
35 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0035

Direct Tel: (207) 624-8689 Receptionist: (207) 624-8603
FAX: (207) 624-8637- TTY/ Hearing Impaired: 1-888-577-6690

JOHN ELIAS BALDACCI
GOVERNOR

Office use only
Cash # _____
License#: _____
43501446 \$ 25.00
43501447 \$102.50
43502619 \$ 15.00

ANNE L. HEAD
DIRECTOR

APPLICATION FOR CERTIFIED ALCOHOL & DRUG COUNSELOR

Application Fee: \$ 25.00
Written Examination Fee: \$ 102.50
Criminal History Record Check Fee: \$ 15.00
TOTAL FEE DUE: \$142.50

Please Make Check Payable to Treasurer, State of Maine
or completed credit card authorization form

☐ NEW APPLICANT ☐ CHANGE OF EMPLOYMENT/AGENCY

☐ REINSTATEMENT previous license number & expiration date: _____

Name: _____
First Middle Initial Last

Any Other Names Used: _____

Contact Address: _____
Street/Box City State Zip Code County

Contact phone: _____ Email Address: _____

Date of birth: _____ Social Security #: _____

Full Name of present agency you are employed at : _____

Agency License Number: _____ Agency Expiration Date: _____

**If the agency has an expired license a copy of the agency's authorization (extension letter) to continue to operate must be submitted with this application.

Including Maine, list each state or any other jurisdiction in which you hold or have ever held any type of professional credential or license

State	License Type	License Number	Expiration date

ATTACH A SEPARATE SHEET IF NECESSARY

**** You must also send the enclosed **Verification of Licensure** form to any other credentialing or licensing body where you hold or have held a license or credential, please follow directions on the form.**

Check appropriate response to the questions. Any **YES** response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

HAVE YOU EVER:

1. Been convicted of any criminal offense (including motor vehicle offenses, but not including minor traffic or parking violations)? ☐ YES ☐ NO
(If YES, please attach a detailed explanation and provide a copy of the court judgment/disposition.)
2. Had any state or territory EVER deny your application for any type of professional license, certificate or registration, or taken any disciplinary action against the license issued to you in that jurisdiction (including, but not limited to, warning, reprimand, fine, suspension, revocation or restrictions in permitted practice, probation with or without monitoring)?
☐ YES ☐ NO
3. Received a sanction from Medicare or from a state Medicaid program?
☐ YES ☐ NO
4. Had hospital or similar health care institution privileges ever been denied or which had previously been granted to you suspended, restricted or withdrawn involuntarily; or have you ever voluntarily surrendered privileges or resigned from staff membership while under peer review? ☐
YES ☐ NO ☐ N/A
5. Had a judgment alleging malpractice liability, a claim settlement by negotiation, arbitration or judgment by a court in a claim of medical malpractice liability in which you are/were named as a defendant with any degree of liability including "nuisance" suits and including settlements made by your insurance company/representatives without your express consent? ☐ YES ☐ NO

Notice regarding Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Notice regarding Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

Affirmation

I hereby certify that all of the information given herein is true and complete to the best of my knowledge and belief.

I understand that falsification of any portion of this application may result in my being denied licensure, or revocation of same, upon discovery.

By submitting this application I understand that the Board of Alcohol and Drug Counselors will rely upon this information for issuance of my license and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension, or revocation of my license if this information is found to be false.

By signing this application, I acknowledge that I have read, understand, and agree to uphold the Alcohol and Drug Counselor Code of Ethics as it appears in the Rules of the Board and that I have been notified that my name may be reported to various disciplinary data banks if I am sanctioned by the Maine State Board of Alcohol and Drug Counselors for violating the Board's Laws and/or Rules.

The Board of Alcohol and Drug Counselors requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

Signature of Applicant

Date

**CADC VERIFICATION
OF CLINICALLY SUPERVISED EXPERIENCE**

Name of Applicant:		
Address:		
City:	State:	Zip Code:
Applicants Job Title:	Telephone #:	
<i>The following section is to be completed by employer or supervisor only</i>		
Name of Agency:		
Dates of Employment: From: _____ To: _____ From: _____ To: _____		
Number of hours of clinically supervised work experience:		
I, the employer or supervisor, of the above named applicant is certifying the information provided on this form is verifiable, factual and accurate.		
Signature: _____ Date: _____		

TO SUPERVISOR COMPLETING THIS FORM:

**THIS FORM IS TO BE RETURNED DIRECTLY TO THE APPLICANT NOT TO THE
BOARD OF ALCOHOL AND DRUG COUNSELORS**

VERIFICATION OF LICENSURE

To be completed by applicant prior to mailing to each state in which you now hold or have ever held a license to practice. Please print. (This form may be copied as necessary)

Name: _____

—

Address: _____

(state) (zip code) Date of Birth: _____

License #: _____ Date
Issued: _____

I hereby authorize the Licensing Authority of the State of _____ to furnish
to the Maine State Board of Alcohol and Drug Counselors the information requested below.

Applicant Signature: _____ Date: _____

**To be completed by the State Licensing Board or Credentialing Agency verifying the above information.
Please complete this section and return to the applicants address above:**

LICENSING BOARD OR AGENCY: This is to certify that the above-named individual was issued License or
License/Credential# _____ to practice as a _____ on:

(date issued) _____ (expiration date) _____

Basis of Licensure:

- ☐ Examination: Indicate the year examination taken and by what State Licensing Board or Credentialing Agency.
- ☐ Grandfathering: Provide documentation of licensure/credentialing requirements at time of initial issuance
- ☐ ICRC Written Examination: _____ ☐ CPM Oral: _____
- ☐ State Exam _____ ☐ CCS Written Examination: _____
- ☐ Other _____
- ☐ Endorsement from _____ (Indicate state)
- ☐ Waiver - Indicate on what basis: _____

Status of License: ☐Active ☐Inactive ☐Lapsed ☐Other: _____

Date license expires/d: _____

Disciplinary Action: Has this license ever been revoked, suspended, limited, surrendered, restricted, placed on
probation, encumbered in any way? ☐Yes ☐No

If yes, please attach a copy of the decision.

Signature: _____

Title: _____

State: _____

Date: _____

(SEAL)



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GOVERNOR

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DIRECTOR



AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: (applicant fees being paid for)		
Contact Address: (applicant fees being paid for)		
City:	State:	Zip Code:
County:		Telephone:
Name of cardholder: (if other than applicant)		
Contact Address: (if other than applicant)		
City:	State:	Zip Code:

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ Visa ☐ MasterCard _____

Card number

Expiration date: ____/____/____ **in the amount of: \$** _____

Signature: _____ **Date:** ____/____/____

PHONE: (207)624-8689
(Office Phone)



PRINTED ON RECYCLED PAPER

1-888-577-6690 (TTY/HEARING IMPAIRED)

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